



HAAS DAS SAVF



Preprimêre Skool / Pre-Primary School

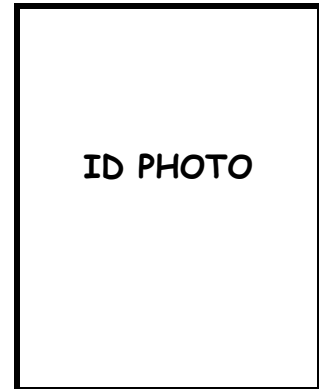
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Posbus 1288
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LADYSMITH
3370

ADMISSION FORM



LEARNERS DETAILS

NAME OF LEARNER: SURNAME: _____

FIRST NAME(S) _____

DATE OF BIRTH: _____ SEX: _____
(Verified Birth and Immunisation certificates attached)

YES NO

PLACE & COUNTRY OF BIRTH: _____

IDENTITY NUMBER OF LEARNER: _____

HOME LANGUAGE: _____

CHURCH / RELIGION DENOMINATION: _____

HOME ADDRESS: _____

PARENTS DETAILS

NAME OF FATHER: SURNAME: _____

FIRST NAME(S) _____

INITIALS _____ TITLE (DR/REV/MR/MS) _____

HOME ADDRESS: _____
_____ POSTAL CODE: _____

POSTAL ADDRESS: _____
_____ POSTAL CODE: _____

TELEPHONE – HOME: _____ CELL: _____

TELEPHONE – WORK: _____ EXT: _____

OCCUPATION: _____

EMAIL ADDRESS: _____

NAME & ADDRESS OF FIRM: _____

_____ POSTAL CODE: _____

NAME OF MOTHER: SURNAME: _____

FIRST NAME(S) _____

INITIALS _____ TITLE (DR/MRS/MS) _____

HOME ADDRESS: _____

_____ POSTAL CODE: _____

POSTAL ADDRESS: _____

_____ POSTAL CODE: _____

TELEPHONE – HOME: _____ CELL: _____

TELEPHONE – WORK: _____ EXT: _____

OCCUPATION: _____

EMAIL ADDRESS: _____

NAME & ADDRESS OF FIRM: _____

_____ POSTAL CODE: _____

GUARDIAN(S) DETAILS

NAME OF GUARDIAN(S): SURNAME: _____

FIRST NAME(S) _____

INITIALS _____ TITLE (DR/MR/MRS/MS) _____

HOME ADDRESS: _____

_____ POSTAL CODE: _____

POSTAL ADDRESS: _____

_____ POSTAL CODE: _____

TELEPHONE – HOME: _____ CELL: _____

TELEPHONE – WORK: _____ EXT: _____

OCCUPATION: _____

NAME & ADDRESS OF FIRM: _____

_____ POSTAL CODE: _____

NEXT OF KIN / FRIEND / RELATIVE'S DETAILS

(Who could be contacted if the parent / guardian is not available and in case of an emergency)

NEXT OF KIN/FRIEND/RELATIVE: SURNAME: _____

FIRST NAMES: _____

RELATIONSHIP TO LEARNER: _____

ADDRESS: _____

_____ POSTAL CODE: _____

TELEPHONE – HOME: _____ CELL: _____

TELEPHONE – WORK: _____ EXT: _____

FAMILY DOCTOR'S DETAILS

NAME OF DOCTOR: _____

TELEPHONE NUMBERS: _____ (W) _____ (H)

MEDICAL AID SCHEME: _____

MEDICAL AID NUMBER: _____

(Verified copy of medical aid membership card attached)

YES

NO

FAMILY HISTORY OF LEARNER

POSITION OF LEARNER IN FAMILY: (1ST, 2ND, etc) _____

IS THE FAMILY COMPLETE? (DIVORCED, SEPARATED, WIDOWED) _____

WHO IS THE LEARNER LIVING WITH? _____

SIBLINGS:

<i>NAME</i>	<i>AGE</i>	<i>SCHOOL ATTENDED</i>

NAME & ADDRESS OF PREVIOUS SCHOOL(S) OR DAY CARE CENTRES ATTENDED:

_____ **POSTAL CODE:** _____

SPECIAL NEEDS OF LEARNER IF PARENTS / GUARDIAN REQUIRES THAT SPECIAL ATTENTION IS REQUIRED IF THE LEARNER SUFFERS FROM: (Asthma, Epilepsy, Allergies, Diabetes, Speech Problem, Easily Fatigued, Frequent Colds/Flu, Coughs, Pain in legs or any other part of the body, etc.) THIS INFORMATION CAN BE GIVEN HERE.

INDEPENDENCE OF LEARNER

- DOES THE LEARNER DRESS AND UNDRRESS HIMSELF/HERSELF? _____
- DRESS WITH OR WITHOUT ASSISTANCE? _____
- CAN THE LEARNER WASH HIMSELF/HERSELF? _____
- IS THE LEARNER INDEPENDENT REGARDING TOILET ROUTINE? _____
- Learners must be independent in the Bathrooms!
- WHICH TERM DOES THE LEARNER USE WHEN HE/SHE WANTS TO GO TO THE TOILET? _____
- HAS THE LEARNER BEEN SEPARATED FROM THE PARENT(S) BEFORE? _____
- WHO WILL BRING THE LEARNER TO SCHOOL IN THE MORNINGS? _____
- DOES THE LEARNER HAVE A GOOD APPETITE? _____
- ANY DISLIKE OR ALLERGIES TO FOODSTUFFS? _____
- IS THE LEARNER ALLERGIC TO ANYTHING ELSE? _____
- IS THE LEARNER A SOUND SLEEPER? (Restless, Wakeful, Bed wetter, Nightmares)

- BED TIME: _____ WAKE UP TIME: _____
- IS THERE ANY OTHER LEARNER'S INFORMATION RELEVANT TO THE ABOVE? (e.g. does the learner suffer from asthma, allergy to bee stings etc.)

WALKING

- AT WHAT AGE DID THE LEARNER START WALKING? _____
- DID THE LEARNER START WALKING SPONTANEOUSLY OR WAS HE/SHE TAUGHT TO WALK? _____
- DID THE LEARNER "CRAWL" OR "SHUFFLE" BEFORE WALKING? _____

SPEECH

- AT WHAT AGE DID THE LEARNER START TALKING? _____
- PRESENT STATE OF SPEECH ABILITY? (Clear, Rapid or No talking at all etc.)

- WHEN TALKING DOES THE LEARNER USE COMPLETE SENTENCES? _____
- PLEASE INDICATE SPEECH DIFFICULTIES: (Stutter, Stammer, etc.)

- DOES THE LEARNER'S SPEECH REQUIRE ATTENTION? _____

VISION

- IS THE LEARNER'S VISION NORMAL? _____
- HAS THIS BEEN CHECKED BY A DOCTOR? _____

HEARING

- IS THE LEARNER'S HEARING NORMAL? _____
- HAS THIS BEEN CHECKED BY A DOCTOR? _____

DENTITION

- AT WHAT AGE DID THE LEARNER GET HIS/HER FIRST TOOTH? _____
- DID THE LEARNER EXPERIENCE ANY TEETHING DIFFICULTIES? _____
- DOES THE LEARNER VISIT THE DENTIST REGULARLY? _____

IS THERE ANY OTHER ADDITIONAL INFORMATION WHICH MAY BE OF VALUE TO THE SCHOOL CONCERNING THE LEARNER, WHICH HAS NOT ALREADY BEEN MENTIONED? (Eg. Thumb sucking, Nail biting, Fear of the dark, Nervous fears etc.)

IN CASE OF AN EMERGENCY CAN ANY OTHER DOCTOR BE CONTACTED IF YOUR FAMILY DOCTOR IS NOT AVAILABLE?

YES

NO

❖ WHO IS RESPONSIBLE FOR THE MONTHLY PAYMENTS OF SCHOOL FEES?

(Name and Surname) _____

PARENT(S) / GUARDIAN(S) SIGNATURE: _____ DATE: _____

For official use only

Enrolment Number: _____

Status of admission: **Approved**

Not Approved

Reasons if not approved: _____

SIGNATURE: _____ DATE: _____



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AGREEMENT – PLEASE COMPLETE AND RETURN TO SCHOOL

RE: SCHOOL FEES – PAYMENTS

• **OPTION 1:**

HALF DAY- (7h15 – 12h15) - R 1 140.00

(This consists of the Pre-Primary Section only).

• **OPTION 2**

FULL DAY - (12h15 – 16h45) - R 1 360.00

(This consists of the Pre-Primary Section until 12.30 as well as After Care facilities).

- **PLEASE MAKE SURE OF YOUR DECISION AS YOU WILL BE LIABLE FOR PAYMENT OF YOUR CHOICE THEREAFTER.**
- **THERE WILL BE NO AFTER CARE FACILITIES AVAILABLE FOR ANY “ONCE OFF” OCCASIONS.**
- **NO CHANGES IN YEAR UNLESS VALID REASON IS GIVEN**

NAME & SURNAME: _____

(Mother / Father / Guardian)

SIGNATURE: _____

DATE: _____